

Service Delivery Area(s) for Statewide HCBS Waiver Providers

Please complete all Agency Information below and check the boxes in the areas where you wish to provide Waiver services. Please make sure you will have adequate staffing and resources to provide Waiver services for all areas checked. If you have any questions please contact your local Area Agency on Aging and Disability.

Agency Name (as it will be listed on the website): _____

Contact Person Receiving Referrals:

Address: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____ **e-mail:** _____

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